

Elsdon Enterprises Limited - Thornbury House

Introduction

This report records the results of a Certification Audit of a provider of aged residential care services against the Health and Disability Services Standards (NZS8134.1:2008; NZS8134.2:2008 and NZS8134.3:2008).

The audit has been conducted by BSI Group New Zealand Ltd, an auditing agency designated under section 32 of the Health and Disability Services (Safety) Act 2001, for submission to the Ministry of Health.

The abbreviations used in this report are the same as those specified in section 10 of the Health and Disability Services (General) Standards (NZS8134.0:2008).

You can view a full copy of the standards on the Ministry of Health's website by clicking [here](#).

The specifics of this audit included:

Legal entity: Elsdon Enterprises Limited

Premises audited: Thornbury House

Services audited: Dementia care

Dates of audit: Start date: 16 September 2021 End date: 17 September 2021

Proposed changes to current services (if any):

Total beds occupied across all premises included in the audit on the first day of the audit: 32

Executive summary of the audit

Introduction

This section contains a summary of the auditors' findings for this audit. The information is grouped into the six outcome areas contained within the Health and Disability Services Standards:

- consumer rights
- organisational management
- continuum of service delivery (the provision of services)
- safe and appropriate environment
- restraint minimisation and safe practice
- infection prevention and control.

As well as auditors' written summary, indicators are included that highlight the provider's attainment against the standards in each of the outcome areas. The following table provides a key to how the indicators are arrived at.

Key to the indicators

Indicator	Description	Definition
	Includes commendable elements above the required levels of performance	All standards applicable to this service fully attained with some standards exceeded
	No short falls	Standards applicable to this service fully attained
	Some minor shortfalls but no major deficiencies and required levels of performance seem achievable without extensive extra activity	Some standards applicable to this service partially attained and of low risk

Indicator	Description	Definition
Yellow	A number of shortfalls that require specific action to address	Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk
Red	Major shortfalls, significant action is needed to achieve the required levels of performance	Some standards applicable to this service unattained and of moderate or high risk

General overview of the audit

Thornbury House is certified to provide dementia level care for up to 33 residents. On the day of audit, there were 32 residents. The service is managed by a non-clinical manager, who is supported by a clinical lead nurse (registered nurse). The manager reports to the owners.

This certification audit was conducted against the health and disability service standards and the district health board contract. The audit process included a review of policies and procedures, the review of resident and staff files, observations and interviews with residents, family members, staff and management.

Families and the GP interviewed were complimentary of the service provided to residents.

The audit has identified that improvements are required around aspects of health and safety, information provided on admission, care plan interventions, hot water temperatures and restraint.

Consumer rights

Includes 13 standards that support an outcome where consumers receive safe services of an appropriate standard that comply with consumer rights legislation. Services are provided in a manner that is respectful of consumer rights, facilities, informed choice, minimises harm and acknowledges cultural and individual values and beliefs.		Standards applicable to this service fully attained.
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The service functions in a way that complies with the Health and Disability Commissioner's (HDC) Code of Health and Disability Services Consumers' Rights (the Code). Information about the Code is readily available to residents and families. Policies are implemented to support residents' rights. Care plans accommodate the choices of residents and/or their family/whānau. Policies are implemented to support rights such as privacy, dignity, abuse/neglect, culture, values and beliefs, complaints, advocacy and informed consent. Complaints and concerns are managed in accordance with HDC guidelines. Relatives spoke positively about the care provided by staff.

Organisational management

Includes 9 standards that support an outcome where consumers receive services that comply with legislation and are managed in a safe, efficient and effective manner.		Some standards applicable to this service partially attained and of low risk.
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The quality and risk management programme includes a service philosophy, goals and a quality and risk management programme. Quality activities generate improvements in practice and service delivery. Meetings are held to discuss quality and risk management processes and results. Satisfaction is monitored via annual satisfaction surveys. Health and safety policies, systems and processes are established to manage risk. Incidents and accidents are reported and investigated.

An education and training programme is in place. Appropriate employment processes are adhered to. There is a roster that provides appropriate staff cover for the delivery of care and support. The residents' files are appropriate to the service type. Residents' files are protected from unauthorised access.

Continuum of service delivery

<p>Includes 13 standards that support an outcome where consumers participate in and receive timely assessment, followed by services that are planned, coordinated, and delivered in a timely and appropriate manner, consistent with current legislation.</p>		<p>Some standards applicable to this service partially attained and of medium or high risk and/or unattained and of low risk.</p>
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The clinical lead nurse/ RN is responsible for the provision of care and documentation at every stage of service delivery. The clinical lead nurse assesses and reviews residents' needs, outcomes and goals with the resident and/or family input. Care plans viewed demonstrate service integration and are reviewed at least six-monthly. Care plans and reviews are completed by a registered nurse.

Each resident has access to an individual and group activities programme. Planned activities are appropriate to the resident group. Family interviewed confirmed satisfaction with the activities programme.

Medication policies reflect legislative requirements and guidelines. The clinical nurse lead and medication competent senior caregivers are responsible for the administration of medicines. Medication charts are reviewed three-monthly by the GP.

Meals are prepared on site and the menu is varied and appropriate. Individual and special dietary needs are catered for. Alternative options are provided. A variety of nutritious snacks are available 24 hours a day. Relatives interviewed were complimentary about the food service.

Safe and appropriate environment

Includes 8 standards that support an outcome where services are provided in a clean, safe environment that is appropriate to the age/needs of the consumer, ensure physical privacy is maintained, has adequate space and amenities to facilitate independence, is in a setting appropriate to the consumer group and meets the needs of people with disabilities.

Some standards applicable to this service partially attained and of low risk.

Chemicals are stored safely throughout the facility. Appropriate policies and product safety charts are available. The building holds a current warrant of fitness. Resident rooms are of sufficient size with an adequate number of shower and toilet facilities for the number of residents. There is wheelchair access to all areas. Appropriate training, information and equipment for responding to emergencies has been provided. There is an approved evacuation scheme and emergency supplies for at least three days. All staff hold a current first aid certificate. External areas are safe and well maintained. Fixtures, fittings and flooring is appropriate and toilet/shower facilities are constructed for ease of cleaning. Cleaning and laundry services are monitored through the internal auditing system.

Restraint minimisation and safe practice

Includes 3 standards that support outcomes where consumers receive and experience services in the least restrictive and safe manner through restraint minimisation.

Some standards applicable to this service partially attained and of low risk.

The organisation actively minimises the use of restraint. At the time of the audit there were no residents using enablers. One resident was using a restraint on an as-needed basis. Staff receive training on restraint minimisation and management of behaviours that challenge.

Infection prevention and control

Includes 6 standards that support an outcome which minimises the risk of infection to consumers, service providers and visitors. Infection control policies and procedures are practical, safe and appropriate for the type of service provided and reflect current accepted good practice and legislative requirements. The organisation provides relevant education on infection control to all service providers and consumers. Surveillance for infection is carried out as specified in the infection control programme.

Standards applicable to this service fully attained.

The infection control programme and its content and detail are appropriate for the size, complexity and degree of risk associated with the service. The clinical lead nurse is the infection control coordinator. There is a suite of infection control policies and guidelines that meet infection control standards and include Covid19 policies. The infection control programme is reviewed annually. Staff receive annual infection control education. Surveillance is used to determine quality assurance activities and education needs for the facility. There has been one outbreak since the previous audit, which was well managed and documented.

Covid19 preparedness included education for staff around donning and doffing personal protective equipment, handwashing, and completion of online training around infection control.

Summary of attainment

The following table summarises the number of standards and criteria audited and the ratings they were awarded.

Attainment Rating	Continuous Improvement (CI)	Fully Attained (FA)	Partially Attained Negligible Risk (PA Negligible)	Partially Attained Low Risk (PA Low)	Partially Attained Moderate Risk (PA Moderate)	Partially Attained High Risk (PA High)	Partially Attained Critical Risk (PA Critical)
Standards	0	39	0	5	1	0	0
Criteria	0	87	0	5	1	0	0

Attainment Rating	Unattained Negligible Risk (UA Negligible)	Unattained Low Risk (UA Low)	Unattained Moderate Risk (UA Moderate)	Unattained High Risk (UA High)	Unattained Critical Risk (UA Critical)
Standards	0	0	0	0	0
Criteria	0	0	0	0	0

Attainment against the Health and Disability Services Standards

The following table contains the results of all the standards assessed by the auditors at this audit. Depending on the services they provide, not all standards are relevant to all providers and not all standards are assessed at every audit.

Please note that Standard 1.3.3: Service Provision Requirements has been removed from this report, as it includes information specific to the healthcare of individual residents. Any corrective actions required relating to this standard, as a result of this audit, are retained and displayed in the next section.

For more information on the standards, please click [here](#).

For more information on the different types of audits and what they cover please click [here](#).

Standard with desired outcome	Attainment Rating	Audit Evidence
<p>Standard 1.1.1: Consumer Rights During Service Delivery</p> <p>Consumers receive services in accordance with consumer rights legislation.</p>	FA	<p>Policies and procedures are in place that meet with the requirements of the Health and Disability Commissioner’s (HDC) Code of Health and Disability Services Consumers’ Rights (the Code). An information pack is provided to residents/families prior to admission and contains information about their rights. The registered nurse (RN) explains the Code to residents and their family during the admission process.</p> <p>Discussions with one facility manager and eight staff (three caregivers, one clinical nurse leader/registered nurse (RN), one diversional therapist, one cook, one maintenance staff and one housekeeper) confirmed their familiarity with the Code and its application to their job role and responsibilities. Six family members interviewed confirmed the services being provided are in line with the Code.</p> <p>Staff are provided with training on the Code. This begins during their induction to the service and continues as a regular in-service (or online) training topic.</p>
<p>Standard 1.1.10: Informed Consent</p> <p>Consumers and where appropriate</p>	FA	<p>The informed consent policy is implemented to guide staff around gaining informed consent. Six resident files reviewed evidenced residents have an activated enduring power of attorney in place (EPOA). Advanced directives and medical care guidance instructions were recorded, and there was</p>

<p>their family/whānau of choice are provided with the information they need to make informed choices and give informed consent.</p>		<p>evidence that family involvement occurs. Family members/EPOA interviewed confirmed that information was provided to enable informed choices, and that they were able to decline or withdraw their consent. The residents in shared rooms had consent documented (sighted). Resident admission agreements were signed. Caregivers and the registered nurse interviewed confirmed verbal consent is obtained when delivering care.</p>
<p>Standard 1.1.11: Advocacy And Support</p> <p>Service providers recognise and facilitate the right of consumers to advocacy/support persons of their choice.</p>	<p>FA</p>	<p>Contact numbers for advocacy services are included in the information folder and in advocacy pamphlets that are available around the facility. Discussions with families identified that the service provides opportunities for the family/EPOA to be involved in decisions. Advocacy services have not been necessary. Age Concern staff provided the elder abuse training for staff in 2020.</p>
<p>Standard 1.1.12: Links With Family/Whānau And Other Community Resources</p> <p>Consumers are able to maintain links with their family/whānau and their community.</p>	<p>FA</p>	<p>Interviews with families confirm that visiting can occur at any time and families are encouraged to be involved with the service and care. More specific visiting restrictions have been implemented during Covid lockdown with family given specific meeting times during level two to restrict the number of visitors at one time. Family frequently take residents out for outings (e.g., garden centre, cafes, hairdressing).</p> <p>Residents are supported to maintain their former activities and interests through the activities programme, led by a diversional therapist. Community involvement such as entertainers and church services are also provided through the activities programme. A van is available for resident outings.</p>
<p>Standard 1.1.13: Complaints Management</p> <p>The right of the consumer to make a complaint is understood, respected, and upheld.</p>	<p>FA</p>	<p>The service has a complaints policy and procedures in place and family/whānau are provided with information about the complaints process on admission. Complaint forms are also available at the entrance. Staff are aware of the complaints process and to whom they should direct complaints. A complaints flow chart is documented for the service.</p> <p>A review of the complaints register evidenced that only one complaint has been lodged since the last audit. This complaint was reviewed and is documented as resolved. Guidelines as per HDC recommendations were met.</p> <p>Family members advised that they are aware of the complaints procedure and how to access complaint forms.</p>

<p>Standard 1.1.2: Consumer Rights During Service Delivery</p> <p>Consumers are informed of their rights.</p>	<p>FA</p>	<p>The service provides written and verbal information to family/enduring power of attorney (EPOA) that addresses the Code, complaints and the role of advocacy services. Annual satisfaction surveys and communication with the facility manager and/or clinical nurse leader are examples of how concerns are raised. Advocacy and the Code information is also available at the entrance to the service. The information pack (informed consent, the Code, advocacy services, a complaints form and admission agreement information. Missing was specific information about the dementia care unit including the need for a secure environment and behaviours that may be observed (link 1.3.1.4).</p>
<p>Standard 1.1.3: Independence, Personal Privacy, Dignity, And Respect</p> <p>Consumers are treated with respect and receive services in a manner that has regard for their dignity, privacy, and independence.</p>	<p>FA</p>	<p>Staff interviewed could describe the procedures for maintaining confidentiality of resident records, resident's privacy and dignity. House rules are signed by staff at commencement of employment. Residents are supported to attend church services held within the facility (two times per month and communion) or attend church services in the community with family if they wish.</p> <p>Three rooms are designated as double rooms with privacy curtains in place. Access to a call bell is adjacent to each bed. Residents suitable for placement in a double room are well known to the staff. Family/EPOA consent is required before a resident is placed in a double room. At the time of the audit, two double rooms were being used.</p> <p>There is an abuse and neglect policy and staff education around this last took place on 20 July 2021. This training is also available for staff as online learning.</p>
<p>Standard 1.1.4: Recognition Of Māori Values And Beliefs</p> <p>Consumers who identify as Māori have their health and disability needs met in a manner that respects and acknowledges their individual and cultural, values and beliefs.</p>	<p>FA</p>	<p>The service has a Māori health plan and an individual's values and beliefs policy, which includes cultural safety and awareness. Discussions with staff confirmed their understanding of the cultural needs of residents and their whānau. Staff confirmed they are aware of the need to respond appropriately to maintain cultural safety. Staff receive training around cultural awareness and the Treaty of Waitangi with the last cultural in-service taking place on 12 October 2020. Cultural needs are identified in the resident's activity plan but were not consistently recorded in the resident's care plan (link 1.3.5.2).</p> <p>There was one resident that identified as Māori at the time of audit. The caregivers and clinical leader interviewed were able describe how they assist in meeting the cultural and spiritual needs of this resident (e.g., turning on the Māori television channel for the resident, music and singing, and ensuring specific spiritual comforts are put into place). The resident's family was interviewed and confirmed that the staff are very caring and do what is possible to meet the cultural needs for this resident.</p>

<p>Standard 1.1.6: Recognition And Respect Of The Individual's Culture, Values, And Beliefs</p> <p>Consumers receive culturally safe services which recognise and respect their ethnic, cultural, spiritual values, and beliefs.</p>	<p>FA</p>	<p>There is a cultural safety policy. Activity goal setting includes consideration of spiritual, psychological and social needs, although this was not consistently recorded in the care plans (link 1.3.5.2). Families interviewed indicated that they are asked to identify any spiritual, religious and/or cultural beliefs during the resident's admission to the service. During the audit, staff were observed to be culturally sensitive when addressing behaviours that challenge.</p>
<p>Standard 1.1.7: Discrimination</p> <p>Consumers are free from any discrimination, coercion, harassment, sexual, financial, or other exploitation.</p>	<p>FA</p>	<p>The staff employment process includes staff signing that they agree to the house rules. Job descriptions describe the role and responsibilities of the position. The orientation programme provided to staff during their orientation covers upholding each resident's dignity, privacy and boundaries. Staff complete training around professional boundaries. Staff interviews confirmed their understanding of their job role and responsibilities. The clinical nurse leader confirmed that the caregivers have a clear understanding about their role as a caregiver and this was confirmed through caregiver interviews.</p> <p>Improvement Note:</p> <p>In an effort to assist the clinical nurse leader, the diversional therapist has completed the 2021 infection prevention and control internal audit and the facility manager (who has caregiving experience) has been completing the 2021 internal audits for disturbing behaviours, care plans, medication procedures and lifting procedures. The facility manager also completed the most recent annual infection control summary report. The service should ensure clinical-based audits are completed by the staff with the technical expertise to do so.</p>
<p>Standard 1.1.8: Good Practice</p> <p>Consumers receive services of an appropriate standard.</p>	<p>FA</p>	<p>A registered nurse is on site 40 hours per week and is available on call 24/7. Additional RN cover is available if needed. A GP visits the facility once a week. Medical care outside regular hours is provided via the public hospital and/or urgent care. Residents are reviewed by the GP every three months at a minimum.</p> <p>The service receives support from the district health board (DHB), podiatry services, dental services and a hairdresser. Strengths include the teamwork amongst staff with reports of good communication received by all staff interviewed. The facility manager has an open-door policy and encourages families to discuss any concerns they may have. This open-door policy is understood by family, confirmed during family interviews. Staff attendance at training is very good with online education options available for those staff who are unable to attend in-services.</p> <p>Family/whānau interviewed reported that they are either satisfied or very satisfied with the services received. A family satisfaction survey is completed annually and confirmed their high levels of</p>

		satisfaction with the services being delivered. The facility manager stated that they are always looking for ways to get residents involved in day-to-day activities that they enjoy doing.
<p>Standard 1.1.9: Communication</p> <p>Service providers communicate effectively with consumers and provide an environment conducive to effective communication.</p>	FA	<p>Families interviewed confirmed they are notified following a change of health status of their family member. This was also evidenced in 10 incident forms reviewed. Families stated they were welcomed on entry and were given time and explanation about services and procedures.</p> <p>Regular resident and/or family meetings are not being conducted but there is evidence of regular communication with families, confirmed via interviews with families and review of resident files. Families commented that they are provided with regular communication from the facility manager and/or clinical nurse leader regarding any changes to the health of their family member, any adverse event, and following a visit from the GP. Resident files also contain evidence of regular communication between the family and facility manager and/or clinical nurse leader via copies of emails. The facility manager reports families are encouraged to pop into the office to speak with her if they have any concerns.</p> <p>The service can access interpreter services as needed. One resident has reverted to her native language. Caregivers interviewed explained how they are able to communicate in an effective manner with this resident. This was observed during the audit. Staff and family can be utilised for translation purposes.</p>
<p>Standard 1.2.1: Governance</p> <p>The governing body of the organisation ensures services are planned, coordinated, and appropriate to the needs of consumers.</p>	FA	<p>Thornbury House provides care for up to 33 dementia level of care residents. At the time of the audit there were 32 residents. All residents were under the aged related residential care (ARRC) contract.</p> <p>The service is part of the Elsdon Enterprises (Ltd) Group who provides governance and management support to the manager. The Elsdon Enterprises (Ltd) Group own five other aged care facilities (three Dunedin, one Milton, one Kaiapoi). A (non-clinical) facility manager is responsible for day-to-day running of Thornbury House, with clinical oversight provided by a full-time clinical nurse leader (link 1.1.7.3). The facility manager had been at Thornbury House since September 2019. She has previous business and caregiving experience. The clinical nurse leader has been employed for one year and has extensive experience in aged care.</p> <p>There is a business plan that includes a mission statement and operational objectives. There is a risk management schedule and documented quality objectives that align with the identified values and philosophy. Review of goals has been documented as being completed. The facility manager reports to the operations manager for Elsdon Enterprises (Ltd) Group who visits the facility once a month (at a minimum).</p>

		The facility manager has maintained at least eight hours annually of professional development activities related to managing a rest home. She attends Aged Care Association meetings when available in Dunedin.
<p>Standard 1.2.2: Service Management</p> <p>The organisation ensures the day-to-day operation of the service is managed in an efficient and effective manner which ensures the provision of timely, appropriate, and safe services to consumers.</p>	FA	During the temporary absence of the facility manager, the clinical nurse leader is second in charge. If the clinical nurse leader is unavailable, RN cover is provided by an RN at one of the other Eldon Enterprises Group aged care facilities.
<p>Standard 1.2.3: Quality And Risk Management Systems</p> <p>The organisation has an established, documented, and maintained quality and risk management system that reflects continuous quality improvement principles.</p>	PA Low	<p>Interviews with the facility manager and staff confirmed their understanding and involvement in the quality and risk management programmes that are being implemented.</p> <p>Policies and procedures and associated implementation systems provide a good level of assurance that the facility is meeting accepted good practice and adhering to relevant standards - including those standards relating to the Health and Disability Services (Safety) Act 2001. A document control system is in place. New policies or changes to policy are communicated to staff, evidenced in meeting minutes. They are reviewed when changes take place or two-yearly (at a minimum).</p> <p>Data collected (e.g., falls, skin tears, challenging behaviours, infections) are collated and analysed. Corrective actions are implemented where data reflects a need for improvement. Quality and risk data are shared with staff via two-monthly staff meetings and during staff handovers.</p> <p>An internal audit programme is in place. Areas of non-compliance include the initiation of a corrective action plan with sign-off by the facility manager. The facility manager and diversional therapist have been assisting the clinical nurse leader by completing clinically related audits which is outside their scope of responsibility (link 1.1.7.3).</p> <p>There is a family satisfaction survey conducted annually. The 2020 survey evidences that families are overall very satisfied or satisfied with the level of service being provided. One corrective action was implemented and signed off to address a perceived lack of understanding of the complaints process and advocacy services. A 2021 satisfaction survey was underway during this audit.</p> <p>Health and safety policies are current. The operations manager is the health and safety officer for all five aged care facilities within the group. There is a health and safety representative at Thornbury</p>

		<p>House (maintenance staff) that is familiar with health and safety requirements. He has completed specific health and safety training. The internal audit programme monitors (building compliance (annual) and safety (six-monthly)). Health and safety issues are discussed at the two-monthly staff meetings with actions documented to address any issues raised. Hazards are identified on the hazard register. A hazard has been identified whereby staff and residents are at risk of an injury when lifting residents who have fallen. A hoist has been purchased for the facility, but staff have not been trained in its use and therefore are unable to use it. Staff receive health and safety training that begins during their orientation to the service. There was no documented evidence to confirm that external contractors receive a health and safety orientation.</p> <p>Falls prevention strategies are in place that includes the analysis of falls incidents and the identification of interventions on a case-by case basis to minimise future falls. Caregivers are kept informed of residents at risk at falling during staff handovers. Sensor mats, a chair sensor alarm, intentional rounding and regular toileting are examples of how falls are being managed. Falls have recently increased with an average of 3.5 falls per month (Dec 2020 – April 2021) and 7.5 falls per month (May 2021 – August 2021). The clinical nurse leader interviewed reported that this is due to a recent increase in the acuity of the residents.</p>
<p>Standard 1.2.4: Adverse Event Reporting</p> <p>All adverse, unplanned, or untoward events are systematically recorded by the service and reported to affected consumers and where appropriate their family/whānau of choice in an open manner.</p>	FA	<p>There is an accident and incident reporting policy. Adverse events are investigated by the clinical nurse leader, evidenced in all 10 accident/incidents reviewed (six unwitnessed falls, two witnessed falls, two episodes of challenging behaviours). Adverse events are trended and analysed with results communicated to staff. There is evidence to support actions are undertaken to try and minimise the number of incidents. Any suspected injury to the head or unwitnessed falls includes neurological observations.</p> <p>Discussion with the facility manager confirmed that there is an awareness of the requirement to notify relevant authorities in relation to essential notifications. No section 31 notifications have been required since the last (surveillance) audit (March 2020).</p>
<p>Standard 1.2.7: Human Resource Management</p> <p>Human resource management processes are conducted in accordance with good employment practice and meet the</p>	FA	<p>There are human resources policies including recruitment, selection, orientation and staff training and development. Six staff files of staff employed since the previous audit were selected for review (one clinical nurse leader, three cooks including the main cook, weekend cook and tea cook, one caregiver, and one cleaner). Staff files included evidence of interviews, reference checking, a signed employment contract and job description and evidence of police vetting. There was also evidence of regular (annual) staff performance appraisals.</p> <p>The orientation package provides information and skills around working with residents with dementia</p>

<p>requirements of legislation.</p>		<p>level care needs and were completed in all staff files reviewed. Health and safety training is also completed for all newly employed staff but is not covered for contractors (link 1.2.3.9).</p> <p>There is an annual training plan in place. This includes in-service training that is complimented by online education modules for those staff who are unable to attend an in-service. Staff interviewed confirmed that they enjoy the learnings. Attendance rates are high. Chemical safety training begins during the new employee's orientation and continues through Southern Hospitality. The clinical nurse leader is interRAI trained.</p> <p>There are 19 caregivers that work in the dementia care unit and 17 have completed the required dementia standards. One staff who has been employed as a caregiver for less than 18 months is in the process of completing the Careerforce dementia standards and one caregiver has recently been employed and plans to enrol in the programme.</p>
<p>Standard 1.2.8: Service Provider Availability</p> <p>Consumers receive timely, appropriate, and safe service from suitably qualified/skilled and/or experienced service providers.</p>	<p>FA</p>	<p>The service has a documented rationale for determining staffing levels and skill mixes for safe service delivery. A roster provides sufficient and appropriate coverage for the effective delivery of care and support. The facility manager and clinical nurse leader are onsite Monday – Friday (40 hours per week). After hours are the on-call responsibility of the CLN. The facility manager assists with call with the understanding that all clinical related issues are triaged to the CLN. Back-up clinical nurse leader support is also available via an RN at one of the other (three) Dunedin-based facilities or the facility located in Milton.</p> <p>The facility is broken down into two wings, the cottage wing with 7 residents, and the house wing with 25 residents. The cottage is staffed with one caregiver from 0700-1100 with a caregiver from the house wing working the remainder of the AM shift (1100 – 1500). The PM shift is staffed with one caregiver from 1500 – 2130 with a caregiver from the house wing working the remainder of the shift (2130 – 2300). One caregiver is responsible for the night shift.</p> <p>In the house wing one caregiver works a long shift (0700 – 1500), and two caregivers work a short shift (0700 – 1100 and 0700 – 1330) with one of the short shift caregivers working in the cottage wing for the remainder of the shift. The PM is staffed with one long shift and two short shifts to 2130 with one of the short shift caregivers working the remainder of the shift in the cottage wing. One caregiver is responsible for the night shift.</p> <p>Staff and family interviewed reported that staffing is sufficient. The caregivers reported that the RN will often extend her hours to assist if there is an unanticipated caregiver staff shortage that is unable to be filled. The facility manager, who has caregiving experience, also assists if there is an unanticipated, last minute staff shortage. During the review of approximately two months of previous staff rosters, all staff vacancies were able to be filled.</p>

<p>Standard 1.2.9: Consumer Information Management Systems</p> <p>Consumer information is uniquely identifiable, accurately recorded, current, confidential, and accessible when required.</p>	FA	<p>The service retains relevant and appropriate information to identify residents and track records. Files and relevant resident care and support information can be accessed in a timely manner. All resident files are in hard copy and stored where they cannot be accessed by people not authorised to do so. Individual resident files demonstrate service integration. Entries are legible, dated and signed by the relevant staff member including designation.</p>
<p>Standard 1.3.1: Entry To Services</p> <p>Consumers' entry into services is facilitated in a competent, equitable, timely, and respectful manner, when their need for services has been identified.</p>	PA Low	<p>The service has admission policies and processes in place. The manager and registered nurse screen all potential residents prior to entry and records all admission enquiries. Family members and EPOA receive an information pack which includes the resident code of rights, and the admission agreement, however there was no information included around what to expect in the dementia unit as required in the ARRC contract. The admission agreement form in use aligns with the requirements of the ARRC contract. Exclusions from the service are included in the admission agreement. The information provided at entry includes examples of how services can be accessed that are not included in the agreement. Family members interviewed confirmed they received information prior to admission and had the opportunity to discuss the admission agreement with the manager.</p>
<p>Standard 1.3.10: Transition, Exit, Discharge, Or Transfer</p> <p>Consumers experience a planned and coordinated transition, exit, discharge, or transfer from services.</p>	FA	<p>There are policies in place to ensure the discharge of residents occurs correctly. Residents who require emergency admissions to hospital are managed appropriately and relevant information is communicated to the SDHB. The service ensures appropriate transfer of information occurs using the 'yellow envelope system'. Relatives are kept well informed about all matters pertaining to residents, especially if there is a change in the resident's condition as evidenced in the sample of files reviewed. The clinical lead initiated the process of transferring a resident to a higher level of care during the audit.</p>
<p>Standard 1.3.12: Medicine Management</p> <p>Consumers receive medicines in a safe and timely manner that complies with current legislative requirements and safe practice guidelines.</p>	FA	<p>There are policies and procedures in place which comply with current legislation. Medicines are stored in accordance with legislation and current guidelines. Medications are pre-packed in robotics and stored in a locked trolley in a locked room. Medicine administration practice complied with the medicine management policy in the medicine round observed. Medications are administered by medication competent caregivers with the clinical nurse leader oversight. Staff that administer medications complete a medicine competency and medication management annually. Medications are prescribed on the electronic medicine management system in accordance with legislative prescribing requirements for all regular and 'as required' medicines. Medications are checked on admission and</p>

		<p>on arrival to the facility and discrepancies are reported to the pharmacy.</p> <p>The service does not have standing orders and verbal orders are rarely used as an electronic system is in place. There was no expired stock on-site on day of audit. Medication fridge temperatures and medication room temperatures are checked and recorded and are within acceptable ranges. The GPs review the medication charts at least three-monthly. Twelve electronic medication charts were reviewed. All medications were prescribed and administered appropriately. "As required" medication has indication for use documented, and efficacy was documented on the electronic medication system and in the progress notes. All electronic charts had photo identification, and allergies were documented.</p>
<p>Standard 1.3.13: Nutrition, Safe Food, And Fluid Management</p> <p>A consumer's individual food, fluids and nutritional needs are met where this service is a component of service delivery.</p>	FA	<p>The service has a small well-equipped kitchen located adjacent to the dining room and meals are served directly to residents. The kitchen is well maintained, and clean and food service manuals are available to guide staff. A food control plan is registered and verified. A dietitian has reviewed the four-week menu which has been developed for all of the facilities owned by the company in July 2021.</p> <p>A resident dietary profile is developed for each resident on admission and is provided to the cook. The kitchen is able to meet the needs of residents who need special diets and the cooks' work closely with the clinical nurse leader. Any changes to nutrition requirements are communicated to the cook by the clinical nurse leader. Diets are modified as required. The cook has been in the role for 11 weeks, she is supported by a tea cook. The main meal is served at lunch time with a lighter option for evening meals. The cook (interviewed) confirmed alternative options are available. Morning, afternoon tea and supper are served to the residents by the care staff. Fluid rounds are provided as required and on hot summer days.</p> <p>Kitchen fridge, freezer and food temperatures are monitored and documented. All food is stored appropriately, decanted dry stock has been dated. Additional nutritional snacks such as yogurt, cheese and crackers, sandwiches, and baking are available to residents 24-hours a day. Family members interviewed were very happy with the quality and variety of food served.</p>
<p>Standard 1.3.2: Declining Referral/Entry To Services</p> <p>Where referral/entry to the service is declined, the immediate risk to the consumer and/or their family/whānau is managed by the</p>	FA	<p>The manager described the reasons for declining service entry to potential residents. Residents would only decline if there were no available beds. Should this occur, the manager communicates this decision to potential residents/family/whanau. Anyone declined entry is referred back to the referring agency for appropriate placement and advice.</p>

organisation, where appropriate.		
Standard 1.3.4: Assessment Consumers' needs, support requirements, and preferences are gathered and recorded in a timely manner.	FA	Six files sampled evidenced that appropriate personal needs information is gathered during admission in consultation with the resident, and their relative/ EPOA where appropriate. This forms the basis of the initial care plan. Resident files sampled evidenced that the InterRAI assessment tool and risk assessments had been used to form the basis of the long-term care plan. The interRAI assessment outcomes were reflected in the long-term care plans where these have been completed. Six-monthly interRAI reassessment has occurred for four residents who had been in the facility for more than six months. Two residents had not been at the service for six months and did not require reassessment.
Standard 1.3.5: Planning Consumers' service delivery plans are consumer focused, integrated, and promote continuity of service delivery.	PA Moderate	All resident files sampled evidenced an initial care plan. the clinical lead utilises an electronic care plan template to complete the care plan, which is then printed and available to the caregivers to reference in the resident's file. The long-term care plans evidenced they were based on the interRAI and outcomes of risk assessment tools, however, not all long-term care plans reviewed described all areas of the supports and interventions required to meet the resident's goals and needs. Short-term care plans have been used for acute changes such as an infection, and transferred to the long-term care plan, if issues continue. Residents and their family/whānau are documented as involved in the care planning and review process, as evidenced in the family notification form in the resident files.
Standard 1.3.6: Service Delivery/Interventions Consumers receive adequate and appropriate services in order to meet their assessed needs and desired outcomes.	FA	When a resident's condition changes, the clinical lead will initiate a referral to nursing service. The GP refers residents to medical specialists when required. Caregivers follow the care plan (link 1.3.5.2) and report progress against the care plan each shift. Staff have access to sufficient medical supplies including dressings. Sufficient continence products (sighted) are available and resident files include a continence assessment and plan. Specialist continence advice is available as needed and this could be described as being accessed through the SDHB. Wound documentation is available and includes assessments, management plans, progress and evaluations. There were two wounds on the day of audit. There was a wound assessment, wound treatment chart and review documented. The clinical nurse lead has access to specialist wound care nurses through the SDHB. Monitoring forms are in place for behaviour management, fluid balance charts, and pain management.
Standard 1.3.7: Planned Activities	FA	The diversional therapist facilitates the activities programme for residents and has been working at

<p>Where specified as part of the service delivery plan for a consumer, activity requirements are appropriate to their needs, age, culture, and the setting of the service.</p>		<p>Thornbury House as a caregiver for 18 years before returning to diversional therapy 10 months ago. The monthly planner is run between 9am and 4.30pm Monday to Friday. There is a range of activities available for caregivers to assist residents in the evenings and weekends including (but not limited to); puzzles, music, wool baskets, and sensory baskets, and sing along.</p> <p>Each resident has an individual activities assessment on admission and from this information, an individual activities plan has been developed and reviewed by the diversional therapist. The diversional therapist records a progress note at least monthly to provide an overview of the resident's activities for the month. The care plan has several sections to include intellectual, physical, social aspects of life. Each section is evaluated at least six-monthly.</p> <p>The individual 24-hour plans sampled were detailed and provide a good description of the residents cognitive and physical capabilities, preferences and previous hobbies and interests. Activities in the home and cottage are provided for each morning and afternoon by the activity's coordinator. Caregivers are also involved in the programme.</p> <p>Each resident is free to choose whether they wish to participate the group activities programme or their individual plan. Participation is monitored. Group activities reflect ordinary patterns of life and include planned visits to the community. Activities include music, group games such as mini golf, balloon games, walking, exercises, newspaper reading, art and crafts. Celebrations such as special days and birthdays are celebrated. There are inter home competitions and entertainment with a sister facility. Church services and communion are held.</p> <p>The service has recently trialled doll therapy with two residents who were not settling. The doll therapy has been very therapeutic for the two residents who are using this. Staff all commented on the almost instant response and the reduction of challenging behaviours. Both residents were observed throughout the audit walking with their baby and talking to the baby. Both were happy and settled.</p> <p>One on one sessions include hand massages, general chats, reading books, reminiscence, or whatever the resident chooses at the time.</p> <p>Photos are sent to relatives via email to inform them of resident's activities. Communication between residents and relatives during lockdown periods were held via phone, social media platforms and emails. Residents are assisted to maintain contacts with community groups. Families interviewed commented positively on the activity programme.</p>
<p>Standard 1.3.8: Evaluation Consumers' service delivery plans are evaluated in a comprehensive</p>	<p>PA Low</p>	<p>The clinical lead evaluates all initial care plans within three weeks of admission. The long-term care plan is reviewed at least six monthly or earlier if there is a change in health status, however, reviews do not always document progress toward meeting all goals, and not all current interventions have been included in the care plan as resident status changes (link 1.3.5.2). There is at least a three-monthly</p>

and timely manner.		review by the GP. Changes in health status are documented in the progress notes and followed up. Short-term care plans are evaluated and resolved or added to the long-term care plan if the problem is ongoing as sighted in resident files sampled.
Standard 1.3.9: Referral To Other Health And Disability Services (Internal And External) Consumer support for access or referral to other health and/or disability service providers is appropriately facilitated, or provided to meet consumer choice/needs.	FA	The service facilitates access to other medical and non-medical services. The clinical lead initiates referrals to nurse specialists and allied health services. Medical specialist referrals are made by the GPs. Referral documentation is maintained on resident files. Referrals and options for care were discussed with the resident and family as evidenced in interviews and medical notes. There are close links with the nurse practitioner for mental health services for older people. Examples were provided where a resident's condition had changed, and the resident was reassessed to a higher level of care. Referrals are documented in the resident notes with follow-up documented in the progress notes and in the plan of care.
Standard 1.4.1: Management Of Waste And Hazardous Substances Consumers, visitors, and service providers are protected from harm as a result of exposure to waste, infectious or hazardous substances, generated during service delivery.	FA	There are implemented policies in place to guide staff in waste management. Staff interviewed were aware of practices outlined in relevant policy. Chemicals are stored safely in locked areas. Chemicals sighted were labelled correctly and safety data sheets and product information is readily available to staff. Gloves, aprons and visors are available, and staff were observed wearing personal protective clothing while carrying out their duties. Staff have completed chemical safety training.
Standard 1.4.2: Facility Specifications Consumers are provided with an appropriate, accessible physical environment and facilities that are fit for their purpose.	PA Low	There are established systems in place to ensure the physical environment and facilities are safe and fit for their purpose. A current building warrant of fitness is posted in a visible location (expiry 28 June 2022). Both internal maintenance personnel and external contractors undertake maintenance. There is a monthly planned maintenance programme in place. Equipment calibration occurs annually. Calibration is currently due but has not been completed as a result of the current Covid-19 lockdown. It is scheduled to take place later in the month. Electrical safety test tag system shows this has occurred. The facility is being maintained in good repair. Maintenance records were reviewed and are clearly documented. Review of the water temperature records reveals resident tap water temperatures occasionally exceed 45 degrees Celsius without evidence of a corrective action. The corridors are wide to promote safe mobility with the use of mobility aids. Residents were observed moving freely around the areas with mobility aids where required. The external areas and gardens are

		<p>well-maintained. There are safe and secure outside areas that include seating and shade around the facility. The lounge area is designed so that space and seating arrangements provide for individual and group activities. There are quiet, low stimulus areas that provide privacy when required with a sensory area that is being developed. There is wheelchair access to all areas.</p> <p>Residents are able to bring in their own possessions and are able to decorate their room as they wish. The facility has a van available for transportation of residents. Those staff transporting residents holds a current first aid certificate. The caregivers and clinical nurse leader interviewed stated that they have the equipment referred to in care plans necessary to provide care although would benefit from hoist training (link 1.2.3.9). Requests have recently been made (and approved) for another chair sensor alarm and shower chair with wheels.</p>
<p>Standard 1.4.3: Toilet, Shower, And Bathing Facilities</p> <p>Consumers are provided with adequate toilet/shower/bathing facilities. Consumers are assured privacy when attending to personal hygiene requirements or receiving assistance with personal hygiene requirements.</p>	FA	<p>There are adequate numbers of communal toilets and shower rooms. Toilets have privacy locks. There are large picture signs on the toilet doors. All bedrooms have access to hand basins. There is appropriate signage, easy clean flooring and fixtures, and handrails appropriately placed. Privacy is maintained at all times. Three rooms are shared rooms and there are curtain screens available between the beds for privacy.</p>
<p>Standard 1.4.4: Personal Space/Bed Areas</p> <p>Consumers are provided with adequate personal space/bed areas appropriate to the consumer group and setting.</p>	FA	<p>There is adequate space in the bedrooms and enough space for the safe manoeuvring of mobility equipment. Residents can personalise their rooms. The three double rooms can be shared by two residents in each. On the day of the audit, two double rooms had shared occupancy and one had single occupancy. Shared rooms are of sufficient size to accommodate the residents. Residents appeared to be orientated to their room.</p>
<p>Standard 1.4.5: Communal Areas For Entertainment, Recreation, And Dining</p> <p>Consumers are provided with safe, adequate, age appropriate, and accessible areas to meet their relaxation, activity, and dining</p>	FA	<p>The layout of the home provides for freedom of movement within a safe and secure environment. There are external walking paths and internal space to allow wandering that is not obtrusive on other residents. There is an open plan lounge/ dining room in the cottage area, a large lounge in the 'house', with two smaller areas off of the lounge utilised as a quiet area and a sensory area with a separate dining area. There is a smaller lounge located at the end of a corridor in the middle of the facility. There is easy access to all communal and external areas for residents using mobility aids.</p>

needs.		
<p>Standard 1.4.6: Cleaning And Laundry Services</p> <p>Consumers are provided with safe and hygienic cleaning and laundry services appropriate to the setting in which the service is being provided.</p>	FA	<p>There are policies in place including cleaning department, use of equipment policy and cleaning schedules. There is also a cleaning schedule/methods policy for the housekeepers.</p> <p>All laundry is undertaken on site. The laundry is well organised and is divided into a “dirty” and “clean” area and staff manage the workload adequately. There are appropriate systems for managing infectious laundry, which laundry staff could describe. There is a comprehensive laundry manual. Chemical data sheets were visible. Cleaning and laundry services are monitored through the internal auditing system and the resident satisfaction surveys. The cleaner’s trolley was attended at all times or locked away in the cleaning rooms as sighted on the days of the audit.</p> <p>Personal protective equipment is available. Staff were observed to be wearing appropriate protective wear when carrying out their duties.</p>
<p>Standard 1.4.7: Essential, Emergency, And Security Systems</p> <p>Consumers receive an appropriate and timely response during emergency and security situations.</p>	FA	<p>There is a disaster management plan to guide staff in managing emergencies and disasters. The facility has an approved fire evacuation plan scheme letter (6 December 2004). Fire evacuation drills are completed every six months, with the last fire evacuation drill occurring on 8 June 2021.</p> <p>There are civil defence supplies available and first aid kit in the nurse’s station, van and civil defence cupboard. The facility has back-up lighting available as per the buildings warrant of fitness. There are sufficient food supplies to provide for its maximum number of residents in the event of a power outage. There is also sufficient emergency water stored (five 150 litre header tanks and bottled water). There are alternative cooking facilities available with a gas hob in the kitchen and a portable gas cooker.</p> <p>The staff is responsible for checking the facility for security purposes on the afternoon and night shifts. The police would be summoned if/when required. The call system is appropriate for the size of the facility and call bells are accessible in the rooms, lounge and dining areas. Suitable residents are also provided with alarm pendants. There is a staff member on duty 24/7 with a current first aid certificate.</p>
<p>Standard 1.4.8: Natural Light, Ventilation, And Heating</p> <p>Consumers are provided with adequate natural light, safe ventilation, and an environment that is maintained at a safe and</p>	FA	<p>There are a variety of heating methods used to maintain a warm environment within the communal areas and bedrooms including heat pumps, ceiling panels and under floor heating. The temperature is thermostat controlled and can be individually adjusted in the resident bedrooms. Families interviewed advised that the bedrooms, lounges and other communal rooms are warm and comfortable. The communal areas and bedrooms have adequate natural light with large windows and ranch slider doors to the secure external areas.</p>

comfortable temperature.		
<p>Standard 3.1: Infection control management</p> <p>There is a managed environment, which minimises the risk of infection to consumers, service providers, and visitors. This shall be appropriate to the size and scope of the service.</p>	FA	<p>The infection control coordinator (IC) is the clinical nurse leader with a defined job description that outlines the role and responsibilities. The IC programme is appropriate for the size and complexity of the service. The programme is approved and reviewed annually (link 1.1.7.3). Meeting minutes are available to all staff and infection control is an agenda topic at staff meetings.</p> <p>There are adequate hand sanitisers placed throughout the facility. Residents and staff are offered the influenza vaccine.</p> <p>Visitors are reminded not to visit if they are unwell. All visitors to the facility are required to complete a wellness declaration and are temperature checked on arrival to the facility. Masks were required to be worn while in the facility in line with level 2 Covid19 guidelines. Adequate supplies of personal protective equipment were sighted during the audit.</p>
<p>Standard 3.2: Implementing the infection control programme</p> <p>There are adequate human, physical, and information resources to implement the infection control programme and meet the needs of the organisation.</p>	FA	<p>Infection control is managed by the infection control coordinator. The infection control coordinator has completed online infection control education. The infection control coordinator has access to the infection control team at the district health board, laboratory services and GP service. All residents requiring commodes are allocated their own commode. Bodily fluids are disposed of, and the bowls are washed and disinfected and returned to the room. Personal protective equipment including gloves, aprons, visors and disinfectant spray is available in the sluice/ laundry area. Shared equipment is wiped with disinfectant spray between use.</p> <p>During lockdown levels 3 and 4, staff uniforms were laundered on site, spare uniforms are available in the case of spillage. Staff arrive to work in their own clothes and get changed at work. Each staff member leaves designated 'work' shoes at work. When lockdown levels return to level 2, staff launder their uniforms at home.</p> <p>Gloves and soap are not available in resident rooms due to resident's safety. Staff interviewed describe taking equipment including gloves with them when attending to resident cares. This was observed during the audit. There are basins in resident rooms and hand sanitizers are placed strategically around the facility (out of the way of residents). The internal audit completed in April 2021 had no corrective actions required.</p>
<p>Standard 3.3: Policies and procedures</p> <p>Documented policies and</p>	FA	<p>The infection control manual outlines a comprehensive range of policies, standards and guidelines and includes the infection control programme, responsibilities and oversight, training and education of staff. The policies have been reviewed and updated by an external provider and reflect relevant legislation</p>

<p>procedures for the prevention and control of infection reflect current accepted good practice and relevant legislative requirements and are readily available and are implemented in the organisation. These policies and procedures are practical, safe, and appropriate/suitable for the type of service provided.</p>		<p>and accepted good practice. Covid19 policies and procedures are available in the Covid 19 folder and these are easily accessible to staff.</p>
<p>Standard 3.4: Education The organisation provides relevant education on infection control to all service providers, support staff, and consumers.</p>	<p>FA</p>	<p>The infection control coordinator is responsible for coordinating/providing education and training to staff. Infection control education is provided annually and includes hand hygiene checks, donning and doffing personal protective equipment, outbreak management. The infection control coordinator has attended covid swabbing education and all staff have completed training around Covid19 using the online platform. Resident education is expected to occur as part of providing daily cares.</p>
<p>Standard 3.5: Surveillance Surveillance for infection is carried out in accordance with agreed objectives, priorities, and methods that have been specified in the infection control programme.</p>	<p>FA</p>	<p>The surveillance policy describes and outlines the purpose and methodology for the surveillance of infections. The infection control coordinator (RN) uses the information obtained through surveillance to determine infection control activities, trends, resources, and education needs within the facility. There is close liaison with the GPs that advise and provide feedback/information to the service.</p> <p>Individual infection reports are entered into a manual log for all infections. A record of individual infections is kept as part of the resident files. Infections are included on a monthly register and a monthly report is completed by the infection control coordinator. There are standard definitions of infections in place appropriate to the complexity of service provided. Infection control data is communicated to staff and management through meetings. Care staff interviewed were knowledgeable about infection control practices.</p>
<p>Standard 2.1.1: Restraint minimisation Services demonstrate that the use of restraint is actively minimised.</p>	<p>PA Low</p>	<p>The restraint policy includes a definition of enablers as voluntarily using equipment to maintain independence. The service philosophy includes that restraint is only used as a last resort. Staff receive training on restraint minimisation and the management of behaviours that challenge. There were no residents using an enabler.</p> <p>One resident who occasionally becomes agitated and tries to get out of her chair, has the legs elevated to keep her safe. The clinical nurse leader reports that the resident's son has given verbal consent for</p>

		this restraint, but this (as needed) use of restraint has not been assessed. Nor is there documented evidence of the restraint being monitored or evaluated.
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Specific results for criterion where corrective actions are required

Where a standard is rated partially attained (PA) or unattained (UA) specific corrective actions are recorded under the relevant criteria for the standard. The following table contains the criterion where corrective actions have been recorded.

Criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1: Service providers demonstrate knowledge and understanding of consumer rights and obligations, and incorporate them as part of their everyday practice relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights.

If there is a message “no data to display” instead of a table, then no corrective actions were required as a result of this audit.

Criterion with desired outcome	Attainment Rating	Audit Evidence	Audit Finding	Corrective action required and timeframe for completion (days)
<p>Criterion 1.2.3.9</p> <p>Actual and potential risks are identified, documented and where appropriate communicated to consumers, their family/whānau of choice, visitors, and those commonly associated with providing services. This shall include:</p> <p>(a) Identified risks are monitored, analysed, evaluated, and reviewed at a frequency determined by the severity of the risk and the probability of change in the status of that risk;</p> <p>(b) A process that addresses/treats the risks associated with service provision is developed and implemented.</p>	PA Low	<p>The maintenance staff is the health and safety representative for Thornbury house. He reports that he accompanies all external contractors and verbally reviews health and safety guidelines with contractors but there is no documented evidence of contractors undergoing health and safety orientation to Thornbury House.</p> <p>Hazards are identified on a hazard register. The use of a hoist has been purchased to reduce the potential injury to residents and staff, but staff have not received training</p>	<p>i) There was no documented evidence to indicate that external contractors undergo health and safety orientation.</p> <p>ii) A hoist is available, but staff have not undergone specific training on the use of the hoist. Examples were provided by caregiver staff that indicates they and the residents are at risk of an injury when assisting in lifting a resident who has fallen.</p>	<p>i) Ensure there is documented evidence of external contractors being orientated to the health and safety procedures of Thornbury House.</p> <p>ii) Ensure staff undergo</p>

		on how to use it and it therefore is not being used.		training on the use of the hoist that was recently purchased. 90 days
<p>Criterion 1.3.1.4</p> <p>Entry criteria, assessment, and entry screening processes are documented and clearly communicated to consumers, their family/whānau of choice where appropriate, local communities, and referral agencies.</p>	PA Low	The information pack contains a leaflet on the resident's code of rights and the advocacy service. Information is provided around what services Thornbury House provide is included in the admission agreement as well as the complaints process, however there was no information included around management of restraint, challenging behaviour, and what to expect in a dementia unit as required by the ARRC contract.	There was no information provided to relatives around what to expect in a dementia unit including management of restraint and challenging behaviour as per the ARC contract	Ensure relative receive information around what to expect in a dementia unit. 90 days
<p>Criterion 1.3.5.2</p> <p>Service delivery plans describe the required support and/or intervention to achieve the desired outcomes identified by the ongoing assessment process.</p>	PA Moderate	The care plan template provides a holistic care plan with resident focused goals and interventions; however the care plan interventions documented were not in line with progress notes documented.	<p>(i). The care plan interventions did not provide sufficient instructions for care staff around resident cares including current mobility status, care of a dressing for a resident with a wound, doll therapy currently utilised for two residents, and one long-term care plan could not be located for a resident who had been in the service for more than three weeks.</p> <p>(ii). There were no individualised triggers, or specific strategies documented around de-escalation/diversion strategies for six of six</p>	<p>(i). Ensure interventions support all current assessed needs.</p> <p>(ii). Ensure the care plans include identification (where possible) of triggers, and document</p>

			<p>resident files reviewed.</p> <p>(iii). There were no individual preferences documented in the templated care plan around values, beliefs, and privacy in six of six resident files reviewed.</p>	<p>individualised strategies of de-escalation/ diversion for residents.</p> <p>(ii). Ensure care plans identify individual values, beliefs and privacy preferences.</p> <p>60 days</p>
<p>Criterion 1.3.8.2</p> <p>Evaluations are documented, consumer-focused, indicate the degree of achievement or response to the support and/or intervention, and progress towards meeting the desired outcome.</p>	PA Low	<p>The evaluation section of the care plan evidenced a general overview of the resident's main issues at the time of the review, which had been completed six-monthly, however the overview does not include all aspects of the care plan.</p>	<p>There was no documentation to evidence progression towards meeting goals for all aspects of the care plan in five residents who had been in the facility for more than six months.</p>	<p>Ensure the care plan review documents evidence towards the resident's achievement towards meeting goals for all aspects of the care plan at least six-monthly.</p> <p>90 days</p>

<p>Criterion 1.4.2.1</p> <p>All buildings, plant, and equipment comply with legislation.</p>	<p>PA Low</p>	<p>Resident water temperatures occasionally exceed 45 degrees Celsius. No corrective action is documented where this occurs.</p>	<p>Hot water temperature checks are routinely completed. When the temperatures at resident taps exceed 45 degrees, a corrective action is not implemented. Two examples were sighted whereby the recording of the temperature was 47 degrees Celsius.</p>	<p>Ensure hot water temperatures for resident's taps and showers do not exceed 45 degrees Celsius.</p> <p>90 days</p>
<p>Criterion 2.1.1.4</p> <p>The use of enablers shall be voluntary and the least restrictive option to meet the needs of the consumer with the intention of promoting or maintaining consumer independence and safety.</p>	<p>PA Low</p>	<p>No enablers were in use. This is a restraint-free facility although there is one resident who is unable to stand yet occasional tries to get out of their chair and is at risk of falling. During these episodes, the legs are raised on the (lazy boy) chair. This use of restraint, which is used on an as-needed basis, has not been assessed as a restraint. Nor is there evidence of monitoring when this restraint is in use. It has been discussed with the resident's son and verbally approved.</p>	<p>The caregivers and clinical nurse leader interviewed indicated that there is one resident, who is at a high risk of falling, and has the legs elevated on their lazy-boy chair when they become agitated and are at risk of trying to stand and potentially fall. This use of restraint has been verbally discussed and approved by the son. But there is no evidence of a restraint assessment being completed. Nor is there evidence of regular monitoring of the resident when restraint is being used.</p>	<p>Ensure restraint use is assessed, monitored, linked to the resident's care plan and evaluated on a regular basis as per restraint policy and procedure.</p> <p>90 days</p>

Specific results for criterion where a continuous improvement has been recorded

As well as whole standards, individual criterion within a standard can also be rated as having a continuous improvement. A continuous improvement means that the provider can demonstrate achievement beyond the level required for full attainment. The following table contains the criterion where the provider has been rated as having made corrective actions have been recorded.

As above, criterion can be linked to the relevant standard by looking at the code. For example, a Criterion 1.1.1.1 relates to Standard 1.1.1: Consumer Rights During Service Delivery in Outcome 1.1: Consumer Rights

If, instead of a table, there is a message “no data to display” then no continuous improvements were recorded as part of this of this audit.

No data to display

End of the report.